COMMUNITY HEALTH
Centers of Oklahoma
Family Health & Dental Clinics

PATIENT AGREEMENT

We welcome you to Community Health Centers, Inc. (*Community Health*) and ***Thank You*** for entrusting us with your Care!! This Agreement is between *Community Health* and the Patient or Individual taking responsibility for payment, if someone other than the Patient.

In this Agreement, the words "you", "your", and "yours" mean the Patient or individual taking responsibility for payment, if someone other than the patient. The word "account" means the account that has been established in your name to which charges are made, and payments are credited. By executing this Agreement, are agreeing to pay for all services that are received.

_____ Initials **Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. Any and all procedures which require the services of an outside lab will be billed separately.

_____ Initials **Payments:** Unless other arrangements are approved by us, in writing, the balance of your statement is due and payable at the time treatment is rendered.

_____ Initials **Insurance:** Insurance coverage is controlled by the contract between you and your insurance company. Community Health Centers, Inc., (*Community Health*) is NOT a party to this insurance agreement, in most cases. *Community Health* will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and insurance benefits. You agree to pay any portion of the charges not covered by insurance.

_____ Initials **Self-Pay:** I am considered **self-pay** and understand that I am responsible for providing *Community Health* all of the paperwork required to determine if/where I fall on the sliding fee scale. I further understand until all fee scale requirements are met, I will be responsible for 100% of all charges.

_____ Initials **Self-Pay:** I understand that as a **self-pay** patient, I am responsible for all office visits, lab, x-ray and other ancillary charges that exceed the Minimum Payment Amount assessed at the time of my visit.

_____ Initials **Past Due Accounts:** If your account becomes past due we will take necessary steps to collect this debt. If we do have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.

_____ Initials **Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee, if YOU request a copy of your records. However, there will be no charge if you request and authorize copies of your records be forwarded to another Provider's office

_____ Initials **Acknowledgment:** I have received, read and understand the Patient Agreement and herein agree to fulfill my obligations to Community Health Centers, Inc., as stated in the Payment Agreement.

_____ Initials **Effective Date:** Your signature on this agreement indicates you agree to all of the terms and conditions contained in the agreement. The agreement is effective as of the date signed and dated below.

_____ _____

Patient/Authorized Individual's Signature Date

_____ _____

Community Health Authorized Representative Date